Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RONALD F KAHN MD
SUITE 4000
1200 BRIARCREST DRIVE
BRYAN TX 77802

Respondent Name
State Office of Risk Management

Carrier's Austin Representative
Box Number 45

MFDR Tracking Number
M4-13-1659-01

MFDR Date Received
March 1, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The reason for the denial was 'Payment denied/reduced for absence of precertification/preauthorization.' Per rule 134.600 of the workers' compensation rules as published by the Texas Department of Insurance only outpatient surgical services provided in a freestanding surgical center or a hospital outpatient department require precert/preauth. The services rendered to [injured employee] on 06/07/2012 were administered here in the physician's office therefore do not meet the criteria for which precert/preauth is required."

Amount in Dispute: $875.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed an in-depth review of the dispute packet submitted by the Robert Khan MD and will maintain its denial for ANSI code 197 – Payment denied/reduced for absence of precertification/preauthorization... Review of the Low Back chapter of the ODG (Exhibit A) does not show a recommendation for a 3 level fact injection to include a SI Joint injection. With these findings, the Office maintains procedures needed to be reviewed by a utilization review physician to substantiate the medical necessity."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2012	64493-50, 64494-50, 64495-50	$875.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §137.100 sets out the treatment guidelines for disability management.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 197 – Payment denied/reduced for absence of precertification/preauthorization
   - 193 – Original payment decision is being maintained. Upon review was determined that this claim was processed properly

Issues

1. Did the requestor obtain preauthorization for CPT codes 64493-50, 64494-50, 64495-50 rendered in an office setting?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   Per 28 Texas Administrative Code §137.100 "(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning)."

   The requestor seeks reimbursement for CPT codes 64493-50, 64494-50, 64495-50 identified as Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level; second level and third level or any additional levels rendered on June 7, 2012.

   Review of the Official Disability Guidelines (ODG) does not address the disputed services; Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level; second level and third level or any additional levels, as a result the disputed services were subject to preauthorization pursuant to 28 Texas Administrative Code §134.600 (p)(12) and 28 Texas Administrative Code §137.100.

2. Review of the submitted documentation finds that the requestor did not submit documentation to support that preauthorization was obtained as required by 28 Texas Administrative Code §134.600 (p)(12) and 28 Texas Administrative Code §137.100. As a result, reimbursement cannot be recommended for CPT codes 64493-50, 64494-50, 64495-50 rendered on June 7, 2012.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 9, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).